

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0000	<p>This visit was for the investigation of complaint #IN00109713.</p> <p>This visit was in conjunction with a post certification revisit to the investigation of complaint #IN00106372 completed on April 24, 2012.</p> <p>COMPLAINT #IN00109713: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W133 and W331.</p> <p>Dates of Survey: June 25 and 26, 2012.</p> <p>Facility number: 000597 Provider number: 15G040 AIM number: 100233420</p> <p>Surveyor: Susan Reichert, Medical Surveyor III-Team Leader</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on June 28, 2012 by Dotty Walton, Medical Surveyor III.</p>		W0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0133	<p>483.420(a)(9) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure clients have the opportunity to communicate, associate and meet privately with individuals of their choice.</p> <p>Based upon observation, record review and interview, the facility failed to ensure 1 of 3 sampled clients (client A), was afforded privacy to make phone calls.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 6/25/12 from 4:45 PM until 6:45 PM. There was an office area with a fax machine/telephone.</p> <p>The Director of Behavioral Health (DBH) was interviewed on 6/25/12 at 5:31 PM. He indicated there was one phone attached to the fax machine located in the office area available to the clients and staff.</p> <p>Daily logs kept in the group home were reviewed on 6/25/12 at 5:45 PM. A log dated 4/25/12 indicated client A had talked to her sister for 25 minutes and client A had told her sister she needed to get off the phone to take a shower. The sister continued to talk to client A and client A finally told her sister, "I'm going</p>			W0133	<p>Service Coordinator will train group home staff to not put the phone on speaker when clients are using it to assure their privacy during conversations.</p> <p>To ensure future compliance, Service Coordinator will monitor bi-weekly for three months.</p>		07/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>to take a shower now...." Logs dated 4/30/12, 6/2/12, 6/8/12, 6/9/12, 6/12/12 and 6/14/12 indicated client A had talked to her sister. On 6/12/12 the log indicated client A's sister expressed concern about client A's finger and stated staff needed to put a band-aid on it "NOW."</p> <p>Client A was interviewed on 6/25/12 at 5:25 PM. She indicated her stepmother did not want her to talk to her sister and staff did not assist her to call her sister.</p> <p>During confidential interview (CI), the person indicated client A's group home staff (unidentified) placed the phone on Speakerphone during conversations.</p> <p>During interview on 6/26/12 at 2:55 PM, client A indicated staff put the phone on Speakerphone and stated, "They turn it on so they can hear our conversation." She indicated it was not okay with her to use the Speakerphone when talking to her sister.</p> <p>The DBH was interviewed on 6/26/12 at 3:45 PM. He indicated staff had indicated they were unaware of how to use the Speakerphone function on the phone, but client A should be able to make calls privately, and he would ensure there was a phone available for client use that afforded privacy during phone calls.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	This federal tag relates to complaint #IN00109713. 9-3-2(a)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based upon interview, observation and record review, for 1 of 3 sampled clients (client A), the facility failed to provide nursing services to timely address a wound on her finger, failed to develop and implement a system to monitor bowel movements, and failed to develop an action plan to address constipation.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 6/25/12 from 4:45 PM until 6:45 PM. Client A had a swollen and red 4th finger on her right hand.</p> <p>The Director of Behavioral Health (DBH) was interviewed on 6/25/12 at 5:31 PM. He indicated client A had a hang nail that was being treated.</p> <p>Daily logs kept in the group home were reviewed on 6/25/12 at 5:45 PM. A log dated 6/12/12 indicated client A's sister called at 6:00 PM and indicated client A's finger is bleeding "which it wasn't," and client A's sister said we needed to put a Band-Aid on it "NOW!"</p> <p>Client A was interviewed on 6/25/12 at</p>			W0331	<p>Community Services Nurses was trained on June 1st, 2012 on the mandatory necessity to physically assess a client. If reported that the client is having non life threatening symptoms, change of condition or complaints that are continuing for more than 24 hours. If it's impossible for the Nurse to assess the client in a timely manner, the client must be taken to the doctor or hospital for further medical evaluation.</p> <p>To ensure future compliance, the Director of Health Services has implemented a log book that the Nurse will take home with them every evening, and record all calls regarding these types of situations. The book will be reviewed by the Director of Health Services (RN) daily to monitor for appropriate response. All phone calls that the nurse receives will be discussed at our daily morning meeting, to assure that appropriate and prompt response was rendered.</p>		07/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>5:25 PM. When asked about her reddened finger, she indicated she had hit it against the wall.</p> <p>Client A's MAR (medication administration record) was reviewed on 6/25/12 at 6:15 PM. Client A's MAR indicated beginning on 6/13/12 she received treatment of Clobetasol (steroid) 0.05 % Ointment-apply every night at bedtime to finger growth and cover with a band-aid.</p> <p>There was no evidence of a bowel movement tracking system in the MAR for client A.</p> <p>Client A's records were reviewed on 6/26/12 beginning at 10:56 AM. A cumulative medical record indicated client A was seen by a dermatologist on 6/6/12 and prescribed the Clobetasol treatment at night to treat client A's 4th distal finger; "pt (patient) states, getting bigger, hurts when bumped." A Medication Change form dated 6/8/12 indicated Clobetasol 0.05% Ointment-apply every night at bedtime to finger growth and cover with a band-aid. The form indicated "pick this medication up from main TODAY, write the new order on the MAR, call with any questions." A health risk plan dated 9/23/09 indicated client A was at risk for constipation and/or bowel obstruction</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>related to medication for arthritis. The plan indicated if constipation is noted after 3 days, or as ordered, notify the nurse. There was no evidence of a tracking system to monitor client A's bowel movements in the record; and no evidence of what action the nurse was to take if client A was constipated after 3 days.</p> <p>The Director of Nursing was interviewed on 6/26/12 at 11:45 AM and indicated there was no evidence in client A's risk plan to indicate what action the nurse would take if client A became constipated.</p> <p>The group home nurse was interviewed on 6/26/12 at 2:20 PM. She indicated client A picked at the skin and had irritated the skin at a team meeting on 6/11/12. She indicated there was not a tracking system in place to monitor client A's bowel movements.</p> <p>The group home nurse was interviewed again on 6/26/12 at 2:30 PM. She indicated client A's Clobetasol ointment had come in on 6/8/12 and stated, "Why they didn't start it until the 13th, I don't know," and "It should have started a lot sooner than that."</p> <p>This federal tag relates to complaint</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	#IN00109713. 9-3-6(a)						